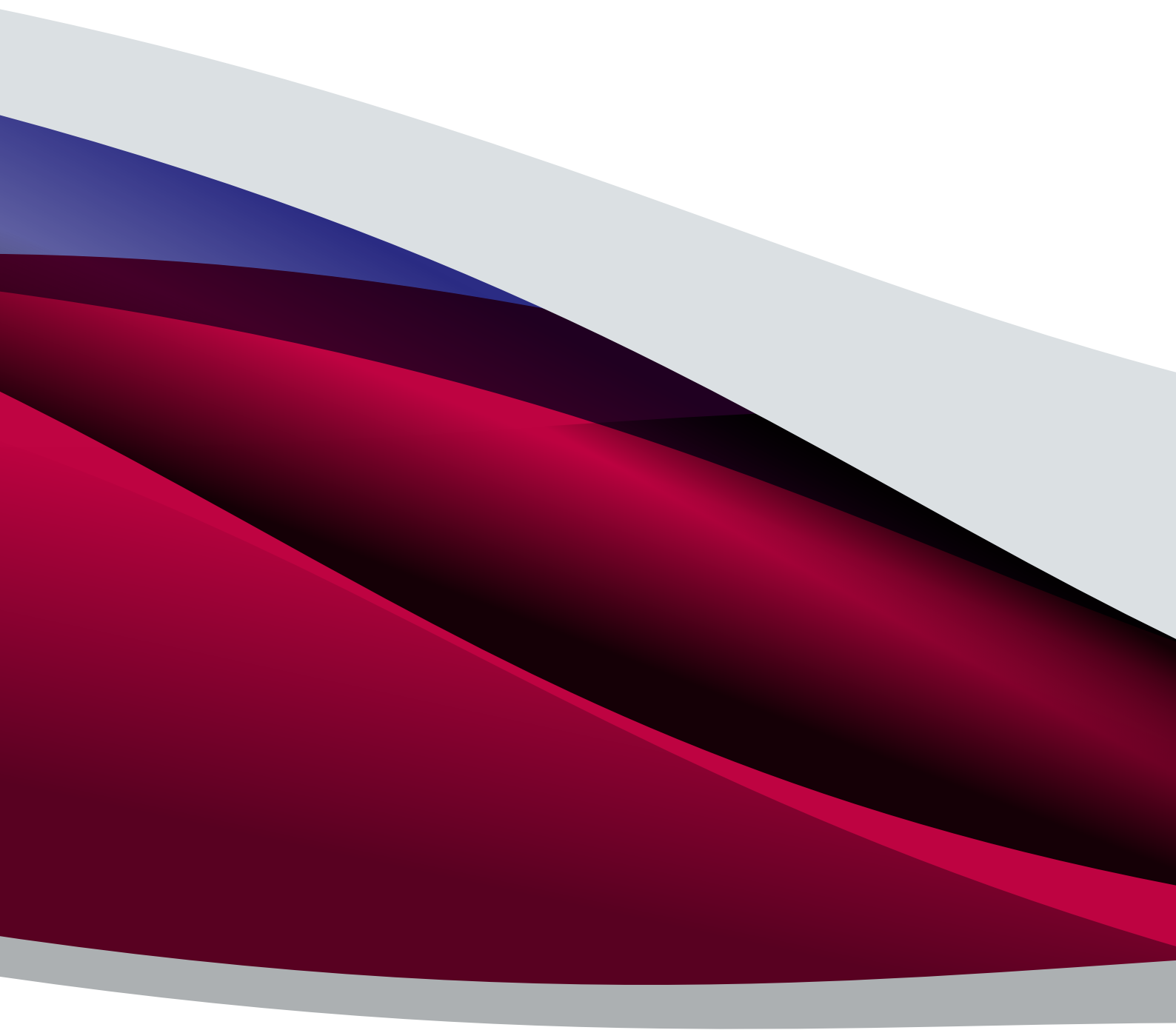
NHS Providers

TOUGH TASK

The NHS delivering for patients and staff in 2018/19

MARCH 2018



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KEY POINTS

- NHS trusts must be set a deliverable task with realistic expectations about demand, performance and financial improvements that can be made given the capacity available.
- In 2017/18 we published *Mission impossible?* predicting that the task set for providers was impossible to deliver. Over the last year, trusts have treated more emergency patients than ever before. They are delivering 1.8% efficiency gains, nine times the UK whole economy average. They are on course to realise more than £3bn in savings.
- Sadly, this will not be enough. The forecast provider sector deficit is at least £930m, over £750m more than planned, taking account of the Budget's extra winter funding. Far from recovering, A&E performance has dropped to the worst levels ever recorded, and waits for routine surgery have significantly increased. There are similar pressures in the community, mental health and ambulance sectors.
- This report analyses the size of the provider task for 2018/19, using survey data from trust leaders and an analysis of current data. This year the task is just as tough, if not tougher.
- We conclude that, next year, patients' experience of care is likely to continue to fall below the standards trusts and the NHS constitution consider acceptable. Based on projected levels of demand and performance, around 3.6 million emergency patients will not be treated within four hours and 560,000 patients needing elective care will not be seen within 18 weeks. The size of the task will add a significant extra burden onto an already hard pressed workforce.
- The report shows that the task set for trusts for 2018/19 once again looks impossible.
- **On A&E performance**, our survey shows only 5% of trusts are confident their area can meet the four-hour A&E target next year. The report shows that the number of trusts needing to improve and the scale of improvement needed to hit the required performance target is extremely ambitious.
- **On elective surgery waiting lists**, our survey shows that 55% of trusts are worried they will not be able to contain the size of their list next year. Given that elective volumes have fallen this year due to winter pressures, workforce and capacity constraints, the assumed increases in outpatient appointments (5%) and elective admissions (3.5%) are too optimistic.
- **On finances**, trusts tell us they would need to deliver more than £4bn worth of savings next year – 20% higher than this year – to deliver the required collective breakeven position. Only 54% indicated they would sign up to their allocated financial target (control total) and, of these, only 35% believed they could meet this target.
- Looking ahead, we need to reset the NHS national planning framework from 2019/2020 onwards. NHS frontline organisations must be a key part of the national level planning process alongside national bodies. National frameworks must be based on realistic projections and assumptions about demand and speed of change. Funding must match the task in hand recognising that, on current resources, we can no longer deliver or recover the NHS constitutional standards. A fully funded, effective, short- and longer-term plan is also needed to address current workforce shortages, which are significantly affecting trusts' capacity to deliver.

1 AN EVER TOUGHER TASK

"As a CEO I find I am needing to say sorry – sorry to our staff for not having managed to fix all this and mostly sorry to patients when I know things are not working the way they should."

Chief Executive, acute trust

In March 2017, NHS Providers published *Mission impossible?* which set out how the task required of frontline NHS trusts in 2017/18 was impossible to deliver. As this financial year draws to a close, the substantial progress that NHS trusts have made over the past 12 months is striking. Despite having experienced the busiest year recorded, and emerging from the toughest winter, on many measures trusts have performed extremely well in 2017/18. The sector has:

- Treated more patients than ever before. In February, the NHS saw over 1.5 million attendances; a 2% rise on February 2017. Despite February's performance against the four-hour standard dropping to the worst it has ever been since data collection began, the NHS still managed to treat, and then admit, discharge or transfer 1,547,784 patients within four hours in February; an increase of 28,500 patients in a year.
- Continued to outstrip UK levels of productivity. The provider sector is delivering productivity improvements of 1.8% (NHS Improvement, 2018), nine times that of the wider UK economy over the past five years (Nuffield Trust, Health Foundation and King's Fund, 2017).
- Continued to deliver a level of efficiency savings higher than other western healthcare systems have been able to achieve. The sector is still on plan to deliver over £3bn savings this year, which would be over £194m (6%) more than last year.
- Seen their partnership working starting to bear fruit. The NHS and social care sector have made substantial efforts to reduce delayed transfers of care, freeing up around 1,500 less daily DTOC beds in January 2018 when compared to January 2017 due to system wide efforts to ensure patients are treated in the most appropriate settings.

However, sadly, for the NHS, its staff and patients, even this level of effort was not enough. Our predictions that the 2017/18 task was impossible have proved all too accurate. Although we await the final data covering the entire year, it is already clear that, despite best efforts:

- trusts will have missed the planned financial deficit of £496m by a significant margin – the forecast deficit at quarter three was just under £1bn, but that included an extra injection of around £240m winter funding in the Budget and it is likely quarter four will be further off plan given the winter pressures trusts have faced
- far from recovering the A&E 95% four-hour standard, performance has deteriorated further. Though, thanks to the focus and effort devoted to urgent and emergency care over the last 12 months, the speed of decline seen in the last few years has slowed down
- again, far from recovering the elective waiting 92% 18-week standard, performance has slipped significantly and we are yet to see the full impact of the operations that had to be cancelled to deal with emergency demand from January 2018 onwards. We expect this to show further slippage.

There are similar stories in cancer waiting time, ambulance targets and across the mental health and community sectors.

Setting NHS trusts an achievable task each year matters. Failing to do so has a number of impacts. It risks:

- the credibility and authority of NHS England, NHS Improvement and the Department of Health and Social Care (DHSC) and trusts losing confidence in the ability of these organisations to lead the service at national level
- trusts being portrayed as failing as they inevitably fall short of delivering an impossible task, however well they perform
- demotivating and disengaging staff as their trust cannot deliver what is asked of it, however hard they all work.

This creates a toxic culture, based on pretence, where trusts are pressurised to sign up to targets they know they can't deliver and then miss those targets as the year progresses. Underlying all this, setting an impossible task weakens accountability and fails to maximise taxpayer value for money because the planning process is neither robust nor rigorous and in year performance and financial management becomes much more difficult.

Setting an achievable task is particularly important in the current trust financial framework. A crucial amount of trust funding (the £1.8bn in the sustainability and transformation fund (STF) in 2017/18, rising to £2.45bn in 2018/19) is allocated based on whether trusts hit their financial and performance targets or not. By the end of 2017/18, around £800m of that funding may not have been earned by trusts, and will therefore be re-allocated to those providers which have hit their financial targets. This means that the funding will likely be concentrated in a smaller number of providers, further worsening the financial problems faced by trusts in most need.

All this risks public confidence in the NHS as the service is seen to consistently fail, year after year. This is already being felt in terms of the attitude of the population towards the NHS. Once one of the most resilient and most loved public services, the latest British Social Attitudes survey showed that satisfaction with the NHS was down to 57%, a 6% drop on last year (Robertson, Appleby and Evans, 2018). Dissatisfaction is now at 29%, nearly double the level recorded in 2014. Three of the main reasons that people gave for being dissatisfied with the NHS were: staff shortages, long waiting times, and lack of funding, which suggests that finally the pressures on the NHS have now entered the public's consciousness.

1

The 2018/19 task

In February 2018, revised planning guidance, *Refreshing NHS plans for 2018/19* (NHS England and NHS Improvement, 2018), set out the delivery requirements for NHS trusts for the coming year, reflecting the additional £1.6bn allocated to the NHS in the November 2017 budget and an additional £540m from the DHSC funds. The guidance contained a significant number of challenging financial and performance objectives for the NHS provider sector, including:

- aggregate financial breakeven position, including a pound for pound improvement in financial performance for the extra £650m added to the provider sustainability fund (PSF, previously the STF)
- A&E target – 90% in September 2018 and the majority of providers meeting 95% by March 2019, as well as reducing delayed transfer of care days to 4000 and reducing inappropriate length of stay
- referral to treatment time (RTT) targets – hold at current number of people on the waiting list and halve the number of patients waiting over 52 weeks
- requirements of *Five year forward view for mental health*
- requirements of national cancer strategy
- requirements of *Transforming care for people with learning disability* strategy
- requirements of national maternity strategy
- continue to implement provider efficiency programmes including *Getting it right first time* (GIRFT)
- further develop their sustainability and transformation plan or integrated care systems.

This list of 'must-dos' is long; and follows an extremely challenging year for trusts. As things stand, it seems very unrealistic that the sector will be able to achieve this in 2017/18.

As with last year's *Mission impossible?*, this report seeks to assess how deliverable the 2018/19 provider task is. It sets out the consequences for patients and staff in section 2, the performance and financial detail in sections 3 and 4 and, in section 5, sets out how, in future, we avoid putting trusts in this impossible situation.

This year, we also draw on the results of a new survey of chief executives and finance directors from 97 NHS trusts and foundation trusts (42% of the sector), following the publication of the 2018/19 planning guidance.

PROTECTING PATIENTS AND SUPPORTING STAFF

2

"[The] high cost improvement target for services may impact upon quality."

Chief Executive, community trust

"[It has the] potential to impact quality of care to achieve our CIP target."

Finance Director, mental health trust

Patients

The recently published Kirkup review into the failings at Liverpool Community Health Trust has given us an important reminder of the implications of prioritising savings over the quality of care. Its findings showed an explicit focus on delivering cost improvement savings – £30m in five years – had a detrimental impact on staffing levels and the quality of services. The review argues that: "Unless there are exceptional circumstances, an annual cost improvement programme of 4% is generally regarded as the upper end of achievability" (Kirkup, 2018).

According to our analysis, next year, NHS trusts are being asked to deliver on average 5.7% cost improvement savings, around £4bn across the sector, after several years of delivering 3.5 - 4% savings. That is around 20% above what the sector is currently forecasting to deliver (£3.3bn). We know trusts will continue to prioritise patient care and quality and that patient safety is paramount. However, across the NHS, both locally and nationally, we must be vigilant.

There are inherent dangers in putting trusts in a position of delivering savings targets they consider beyond reach, as we have seen in the Kirkup review into Liverpool Community Health Trust and as we saw previously with the Francis report into Mid Staffordshire NHS Foundation Trust.

This year, the number of patients waiting 12 or more hours on a trolley in A&E, reached 1,043 in December 2017; the highest level since the data collection began in August 2010. In February, the number of mixed sex ward breaches increased to over 2,000, the highest in seven years. Over the winter, one in eight (13%) patients were waiting in ambulances for more than 30 minutes. In this scenario, performance is not just a patient experience issue, it becomes a quality and safety issue too.

Next year, patients' experience of care is likely to continue to fall below the standards trusts consider acceptable. In 2018/19, anticipated performance against the two key performance standards, means many patients are likely to have to wait longer for care:

- A&E performance: based on current performance and forecast demand, and assuming no improvement can be achieved, we estimate that in the coming year, over 3.6 million patients will not be treated within four hours, around 68,000 patients more than 2017/18.
- Elective care: based on the trends over the recent years, the size of the elective waiting list at the end of March 2019 will be 4.07 million, above that forecast for March 2018. To meet the 92% standard, we estimate that 3.74 million patients would need to be waiting less than 18 weeks, meaning that almost 155,000 patients will be waiting longer than they should.

National decisions highlight the increasing trade offs between available funding and meeting patients' expectations:

- prioritising the A&E target means accepting that performance for routine treatment might need to slip as has happened this winter.
- there are now delays and restrictions on the funding of new treatments and interventions. As NHS England highlighted in 2017, the NHS can no longer be expected to implement all new advisory standards from the National Institute for Clinical Excellence (NICE): "NICE guidelines can only expect to be implemented locally across the NHS if in future they are accompanied by a clear and agreed affordability and workforce assessment at the time they are drawn up" (NHS England and NHS Improvement, 2018).

NHS performance statistics over the last three years show that we have now reached the point where the NHS is no longer able to deliver all that is constitutionally required of it on behalf of patients without significant extra funding and capacity and a means of addressing current workforce shortages.

Staff

The size of increased savings levels required and the need to improve performance and patient throughput to hit the required performance standards in 2018/19 risk adding a significant extra burden onto an already hard-pressed workforce.

One of the constants of the last three winters has been the stories of NHS staff going above and beyond to continue to provide care in extremely challenging circumstances. The latest staff survey results depict a worrying state of affairs in terms of the impact of staff engagement and morale across the NHS (NHS Survey Coordination Centre, 2018), which are very likely to continue into 2018/19:

- over half of the workforce (58%) worked additional unpaid hours, a sign of the extra discretionary efforts trusts must make to meet the current level of demand
- over a third (38%) of staff reported feeling unwell due to work related stress in the past 12 months, another symptom of a pressurised workforce
- only around a third (31%) of staff thought their organisation had enough staff to support them to do their job properly
- overall the level of staff engagement has declined, the first time since 2014.

According to research from the King's Fund in 2017: "the growing gap between demand for services and available resources means that staff are acting as shock absorbers, working longer hours and more intensely to protect patient care... this is particularly worrying given the well-established link between staff wellbeing and the quality of patient care" (King's Fund, 2017).

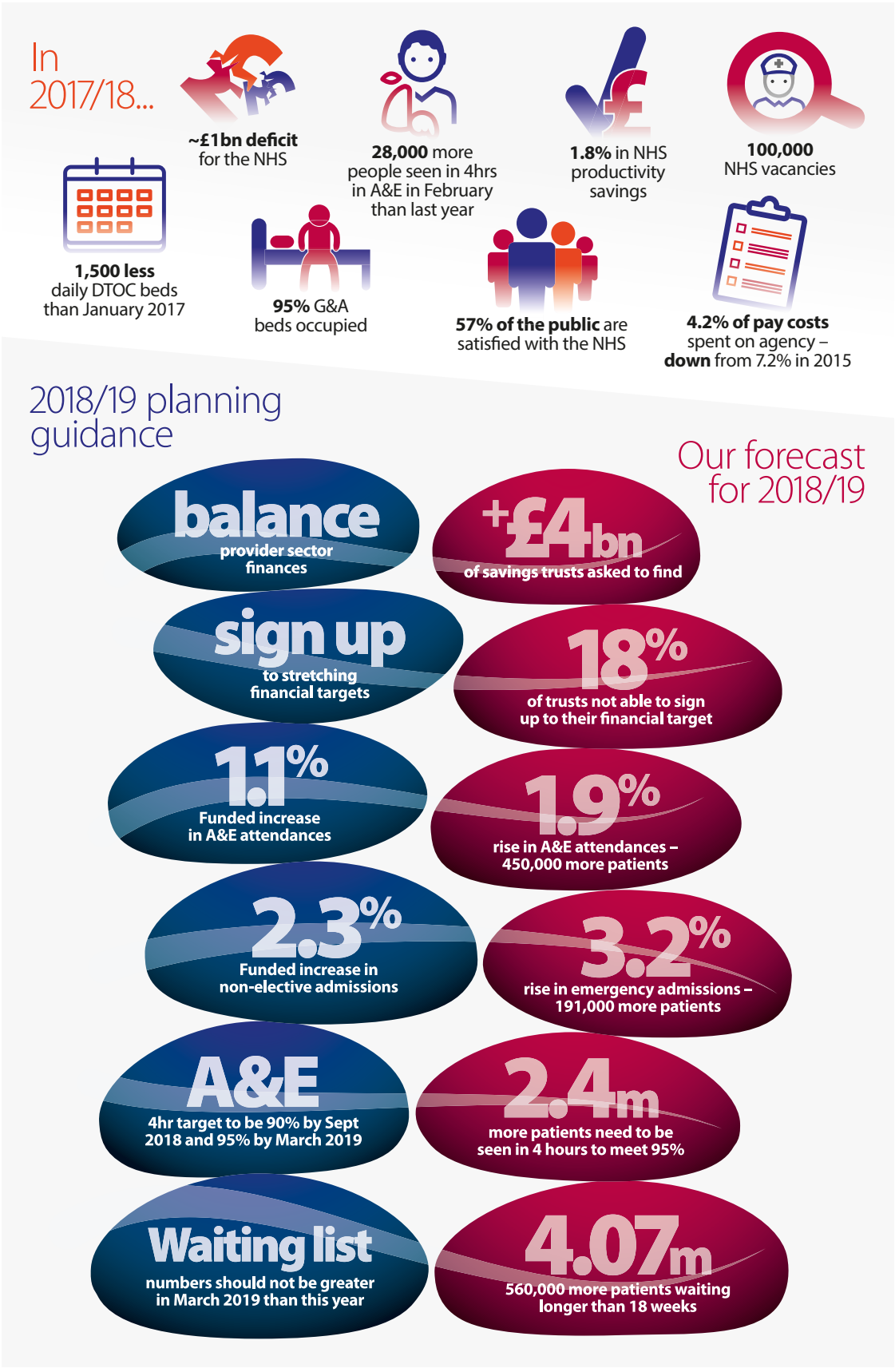
This pinpoints the profound implications on staff of continuing to ask them to deliver objectives which we know are undeliverable given the current level of resources. Exacerbated by the intense winter pressures we have seen for over three years in a row, we are now at a point where high levels of staff burnout have been reported.

The additional work carried out by the NHS has only been possible through the dedication of staff. This extra level of discretionary effort cannot be relied on as an ongoing resource, as we argued at the end of last year in our workforce report *There for us: a better future for the NHS workforce* (NHS Providers, 2017).

The draft workforce strategy *Facing the facts, shaping the future* finally sets out the thinking to inform a longer-term strategy for the NHS workforce. This is a much needed contribution to considering the future sustainability of the NHS over next decade. However, for 2018/19, it is vital to help frontline organisations retain the workforce they need in the short term. Setting consistently unrealistic performance and financial targets only catches the workforce in a perpetual cycle of failure, further undermining morale and levels of engagement.

A TOUGH TASK FOR THE NHS

Balancing delivery against demand in 2018/19



THE PERFORMANCE CHALLENGE

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The planning guidance for 2018/19 requires the NHS to achieve aggregate performance against the four-hour A&E standard of 90% for the month of September 2018, and for the majority of providers to achieve 95% for the month of March 2019. It also states that there cannot be more patients on the elective (RTT) waiting list in March 2019 than in March 2018, and that the number of waits over 52 weeks must be halved. This is, in itself, a further departure from the constitutional standards that reflect safe and high quality care, that people have been told to expect and that trusts want to meet.

In this section, we look at what might happen to the A&E and RTT performance standards in 2018/19. We also look at how the projected growth in patient demand matches the level of activity funded in 2018/19.

Context

As we approach 2018/19, there is insufficient capacity across the health and care system in terms of beds, staff, and different types of services to meet the demand, and increases in demand, trusts are experiencing. As recent performance data has shown, this means that the NHS is now unable to deliver the key constitutional standards.

- **Beds**. There are not enough beds to meet demand. General and acute bed occupancy had already reached 95% at the end of February, and there were 23% more escalation beds open compared to the same time last year. There is currently no system-wide plan to increase the number of beds across the NHS.
- **Staff**. By the end of December, one in twelve NHS positions were vacant. This translated to 35,835 nurse vacancies and 9,676 medical vacancies (NHS Improvement, 2018).
- **Community services**. There is not sufficient community care in place to support patients in out of hospital settings, Furthermore, the number of district nurses has decreased by 41% between November 2010 and November 2017.
- **Mental health services**. Although mental health funding is now increasing, this is not consistently reaching the frontline, as reported in section 4. A failure to ensure adequate mental health services both undermines quality and safety in these services as well as putting a strain on other parts of the system, in particular the acute and ambulance service. 39% of chief executives and finance directors in our survey were worried about progress being made in implementing the *Five year forward view for mental health* in 2018/19.
- **Ambulance services**. The demand for ambulance services over winter 2017/18, combined with the need to implement the ambulance response programme have stretched ambulance services to the limit. As one director of strategy told us: "It is now commonplace over the winter period for A&E corridors to become full of patients and ambulances to queue outside emergency departments. It means that patients in the community could be having heart attacks and strokes when there are no ambulances available to provide an emergency response. The risk of harm is now transferring from those in corridors to patients in the community needing an ambulance" (NHS Providers, 2018).

This highlights that even before we have started 2018/19, the NHS is under substantial pressure, and is facing a significant gap between demand and capacity.

The prognosis for 2018/19

Demand

The planning guidance suggests funding will grow to accommodate various activity increases expected across the NHS in 2018/19. Our analysis suggests that, based on projecting 2017/18 demand levels forward, these activity levels significantly underestimate the demand the NHS will face and that the service will therefore need to absorb (table 1).

Table 1

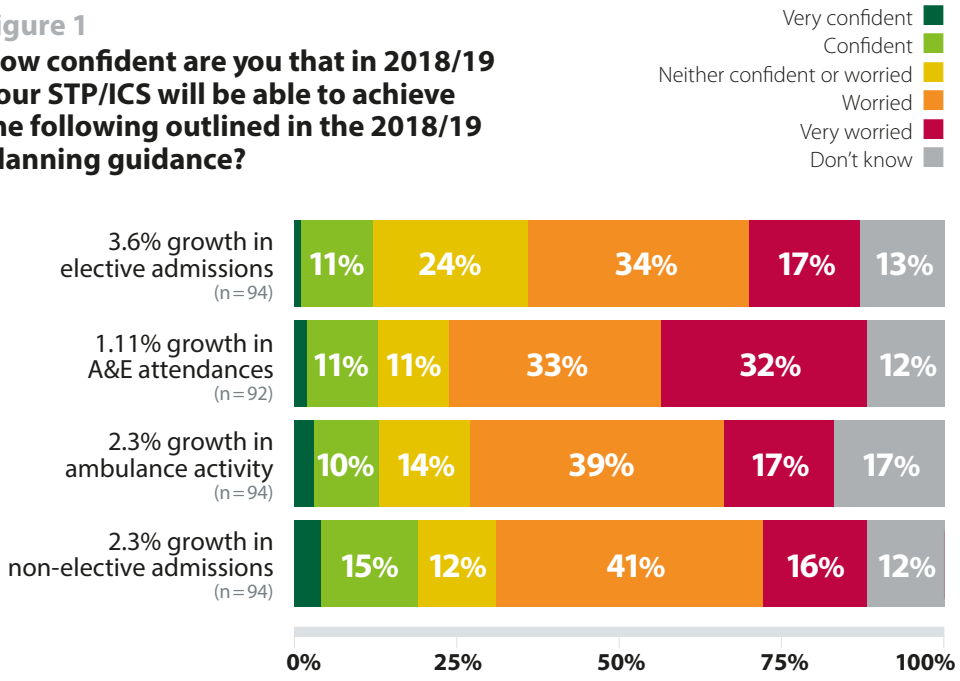
Activity funded in the 2018/19 planning guidance compared to current projections

Type of activity	Activity levels funded in 2018/19	Projected activity (based on 2017/18 year to date activity)	Gap between projected activity and funded activity levels
A&E attendances	1.1%	1.9% 24 million attendances, an increase of around 450,000 patients	0.8%
Emergency admissions	2.3%	3.2% 6 million emergency admissions, an increase of around 191,000 patients	0.9%

This gap between demand and funding has, of course, been a consistent story for the NHS in recent years. Advances in clinical practice will only take us some of the way to closing this gap. We also need to create more comprehensive capacity in and outside of hospitals. Without it, additional demand will put further strain on a system which is already pushed to its limits. On current plans the NHS – both commissioners and providers – will need to absorb this additional demand without additional funding.

Figure 1

How confident are you that in 2018/19 your STP/ICS will be able to achieve the following outlined in the 2018/19 planning guidance?



Our survey findings confirm this. Around two thirds (65%) doubt their sustainability and transformation partnership (or integrated care system) will manage to keep demand within planned levels for A&E attendances. More than half have similar concerns about demand for non-elective admissions and ambulance activity (figure 1).

It is worrying that more than half of providers are concerned that the central assumptions in the planning guidance around emergency, elective and ambulance demand will not be met. This casts considerable doubt on the ability of providers to meet their performance and financial targets in 2018/19.

The story is different, but equally challenging, for elective demand, where activity levels have actually decreased in 2017/18 (table 2). Trusts have struggled to fulfil planned-for demand, primarily due to a lack of bed capacity given that emergency care has displaced routine work. As a result, elective income was down 2.5% (£174m) against plan at the end of December 2017.

Table 2
Activity funded in the 2018/19 planning guidance compared to current projections

Year	Elective Admissions	Year on year change
2011/12	5,119,197	–
2012/13	5,186,705	1.3%
2013/14	5,425,749	4.6%
2014/15	5,581,588	2.9%
2015/16	5,754,332	3.1%
2016/17	5,911,623	2.7%
2017/18 forecast	(YTD 4,367,839) 5,823,785	-1.5%

As highlighted by Rob Findlay, a waiting times expert, the elective admission rate fell dramatically in January, as trusts responded to peak winter pressures and the decision by the National Emergency Preparedness Panel (NEPP) to stop non-urgent care (Findlay, 2018). In the past two months, the number of elective admissions has fallen significantly, and in January, the admission per working day dropped to 13,400, the lowest January figure on record.

Given the picture for this year, it is inevitable that, without radical changes, trusts will struggle to meet expected levels of demand and deliver on key performance measures.

A&E performance

A&E performance is the worst it has been since data collection began in August 2010, with 85% of all attendances being treated and then admitted, discharged or transferred within four hours and 76.9% of patients at major A&E (type 1) departments being treated within four hours. In February 2018, the latest monthly data available, only four major A&E departments met the four-hour standard (figure 2).

Figure 2

Percentage of all patients seen within four hours at trusts with a major A&E department

62.8	63.1	67.5	67.6	69.0	69.2	69.3	69.5	70.2	70.7
71.5	71.6	71.7	72.1	72.1	73.6	73.8	73.8	74.1	74.4
74.6	74.7	75.0	75.4	75.6	75.8	76.6	76.9	77.2	77.3
77.7	77.7	77.8	77.9	78.0	78.1	78.2	78.3	78.4	78.4
78.8	78.8	78.9	79.2	79.3	79.5	79.6	79.6	79.8	80.2
80.5	80.6	80.9	81.1	81.1	81.3	81.3	81.4	81.7	81.8
82.1	82.3	82.4	82.5	82.8	82.8	82.9	83.0	83.3	83.3
83.4	83.5	83.6	83.8	83.9	83.9	84.1	84.6	84.6	84.8
85.0	85.1	85.2	85.6	85.9	86.0	86.0	86.0	86.1	86.3
86.5	86.5	86.8	86.8	87.0	87.0	87.1	87.1	87.2	87.3
87.3	87.4	87.5	87.6	87.6	87.7	87.7	88.3	88.4	88.5
88.8	88.9	89.0	89.3	89.9	89.9	90.0	91.3	91.6	91.7
91.8	92.1	92.6	92.7	92.9	93.0	93.2	93.7	93.8	94.4
94.4	94.4	94.6	95.5	96.6	97.4	97.6			

Our survey data and other evidence shows that it looks impossible for providers to deliver this recovery trajectory in 2018/19 set in the planning guidance:

- Only 5% of trusts responding to our survey indicated that they were confident their STP/ISC could meet the 95% four-hour target, a long way short of the 50% plus required by March 2019. 76% were worried or very worried about their STP/ICS's ability to deliver this performance (figure 3).
- With current A&E performance at 85%, and with attendances due to increase by 1.9% next year, the NHS would need to treat an extra 2.4 million people within four hours to meet the constitutional target of 95%. That is the equivalent of each trust having to treat an additional 14,000 patients within four hours in 2018/19.
- If the NHS fails to improve performance and it holds at current levels, we estimate over 3.6 million patients will not be treated within four hours in 2018/19.

A&E performance has fallen significantly in each of the last three complete financial years and, although the speed of decline has lessened, there will be a drop in 2017/18 as well, given performance to date.

In this context, the scale of improvement required to deliver the recovery trajectory in the planning guidance looks far too optimistic. For example, an analysis of the improvement needed in the 137 major A&E departments featured in figure 2 above suggests that, for a majority of these departments to deliver 95% by March 2019 as required, assuming those current closest are most likely to hit the target:

- 17 trusts (12%) would need to improve their performance by up to 5% compared to their February 2018 performance

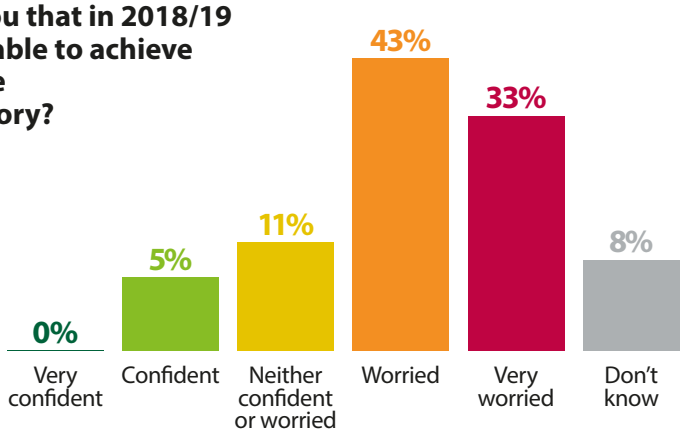
- 36 trusts (26%) would need to improve their performance by up to 10%
- and a further 12 trusts (9%) would need to improve by more than 10%.

While a small number of trusts have improved their performance year on year, there is nothing to suggest that this scale or width of improvement is deliverable without a major system change, such as a very large jump in capacity, funding or staffing levels, none of which are envisaged in the planning guidance.

Figure 3

How confident are you that in 2018/19 your STP/ICS will be able to achieve the A&E performance improvement trajectory?

(n=95)

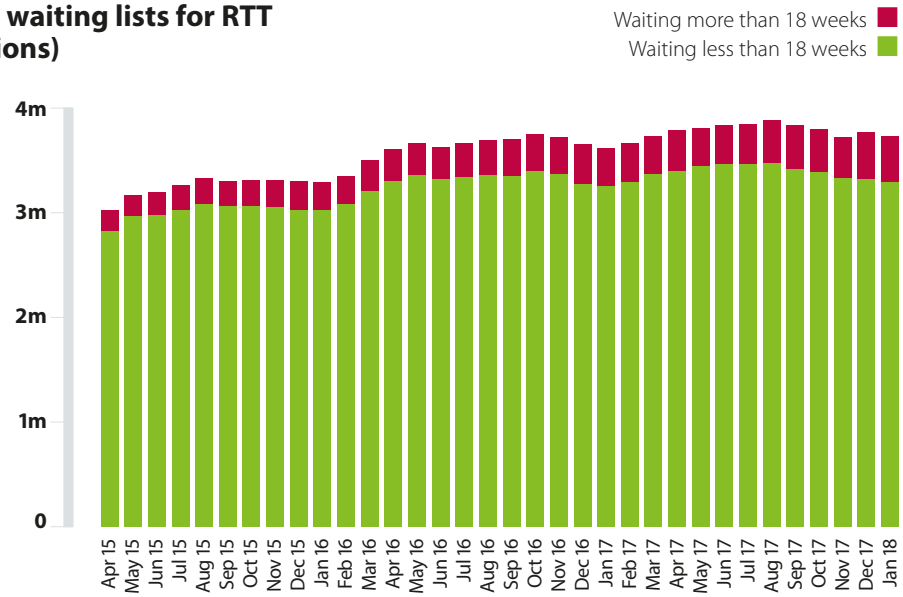


Elective waiting time performance

Performance against the 18-week waiting time target has fallen to its lowest point since March 2009 although the vast majority of patients (88.2%) are still being seen within 18 weeks (figure 4).

Figure 4

Total waiting lists for RTT (millions)



When we factor in non-reporting trusts, the size of the waiting list is nearly back to around 4 million patients (Findlay, 2018), the size it was in 2007 when reporting first began. Performance against the target now sits at 87.9% and we have used this figure for the subsequent analysis.

The planning guidance states that there cannot be more patients on the waiting list in March 2019 than in March 2018. It also suggests that the number of waits over 52 weeks must be halved.

Again, our analysis, which factors in non-reporting trusts, shows that providers will struggle to stabilise elective performance next year:

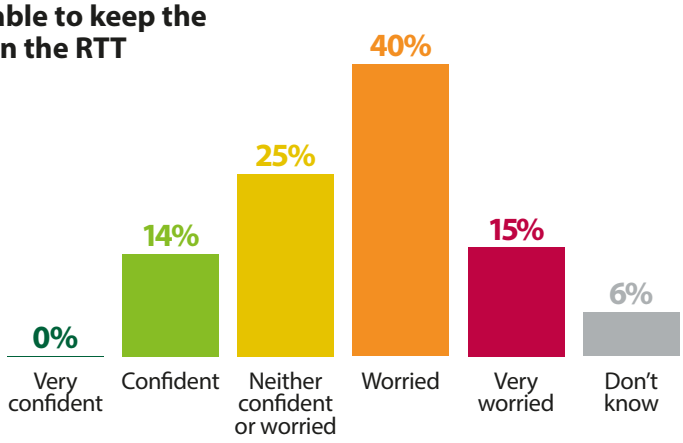
- Based on the trends over the past few years the size of the elective surgery waiting list will reach 4.07 million by the end of March 2019. Unless performance improves this would be greater than forecast for March 2018.
- Extrapolating 2018/19 performance from current trends, based on the increasing size of the waiting list, 3.58 million patients will be treated within the 18-week standard, meaning that 492,500 patients would be waiting over 18 weeks for treatment – 10,000 more than we have at the moment.
- But even this seems optimistic, and would require performance to hold at current levels. In fact, since January 2014 performance against the standard has fallen by between 1.5% and 2% each year. If performance were to slip by 1.75%, the standard would drop to 86.2% which could mean that the number of people waiting more than 18 weeks could increase to 560,000 by March 2019, over 79,000 more than at the moment.
- By January 2018, the number of one-year waiters rose to above 2,000 (if non-reporting trusts are factored in), the highest since 2012. Although tackling this is a priority for the provider sector for 2018/19, achieving it will be challenging.

This is further confirmed by our survey results. Only 14% of trusts responding to our survey indicated that they were confident their STP/ICS would be able to keep the number of patients on the waiting list stable. Over half (55%) were worried about their STP's/ICS' ability to meet this target locally (figure 5).

Figure 5

How confident are you that in 2018/19 your STP/ICS will be able to keep the number of patients on the RTT waiting list stable?

(n=95)



The planning guidance envisages an increase in elective activity of 4.9% for outpatient attendances and 3.6% for elective admissions as the level of activity required to meet the target of holding list size and halve the number of long waiters.

But this takes no account of the constraints trusts will face in delivering these increases. These are:

- elective work has been displaced by emergency work throughout 2017/18 and there is no reason to believe this will change in 2018/19 – at the moment, there are no comprehensive plans in place to significantly increase available emergency capacity during 2018/19
- trusts report that they face physical space constraints in expanding their elective capacity to the extent required
- trusts report that they face major constraints in recruiting the staff required to deliver this scale of increase
- as outlined above, due to the way these constraints operated in 2017/18, elective activity has actually fallen by 1.5% so far this year. There is nothing to suggest that trusts can reverse this trend to the extent of delivering a 4.9% increase in outpatient attendance and 3.6% in elective admissions. Trust chief executives suggest they will do well to deliver the same amount of elective activity in 218/19 as they did in 2017/18.

Turning around the current performance against the constitutional standards will be a top priority for trusts in 2018/19, and recovering A&E performance to unlock additional funding will be central to planning for acute services. But the gap between planned and actual growth in demand cannot continue to widen as it leaves both providers and commissioners in the cycle of having to absorb the financial burden associated with unrealistic assumptions. We explore what we need to do in response to this in section 5.

4 FINANCIAL BALANCE

The planning guidance for 2018/19 requires the NHS to achieve a financial breakeven position next year, including a pound for pound improvement in financial performance for the extra £650m added to the provider sustainability fund (PSF). In this section, we look at what might happen to provider finances in 2018/19. We also look at how trusts are responding to their financial targets, known as control totals.

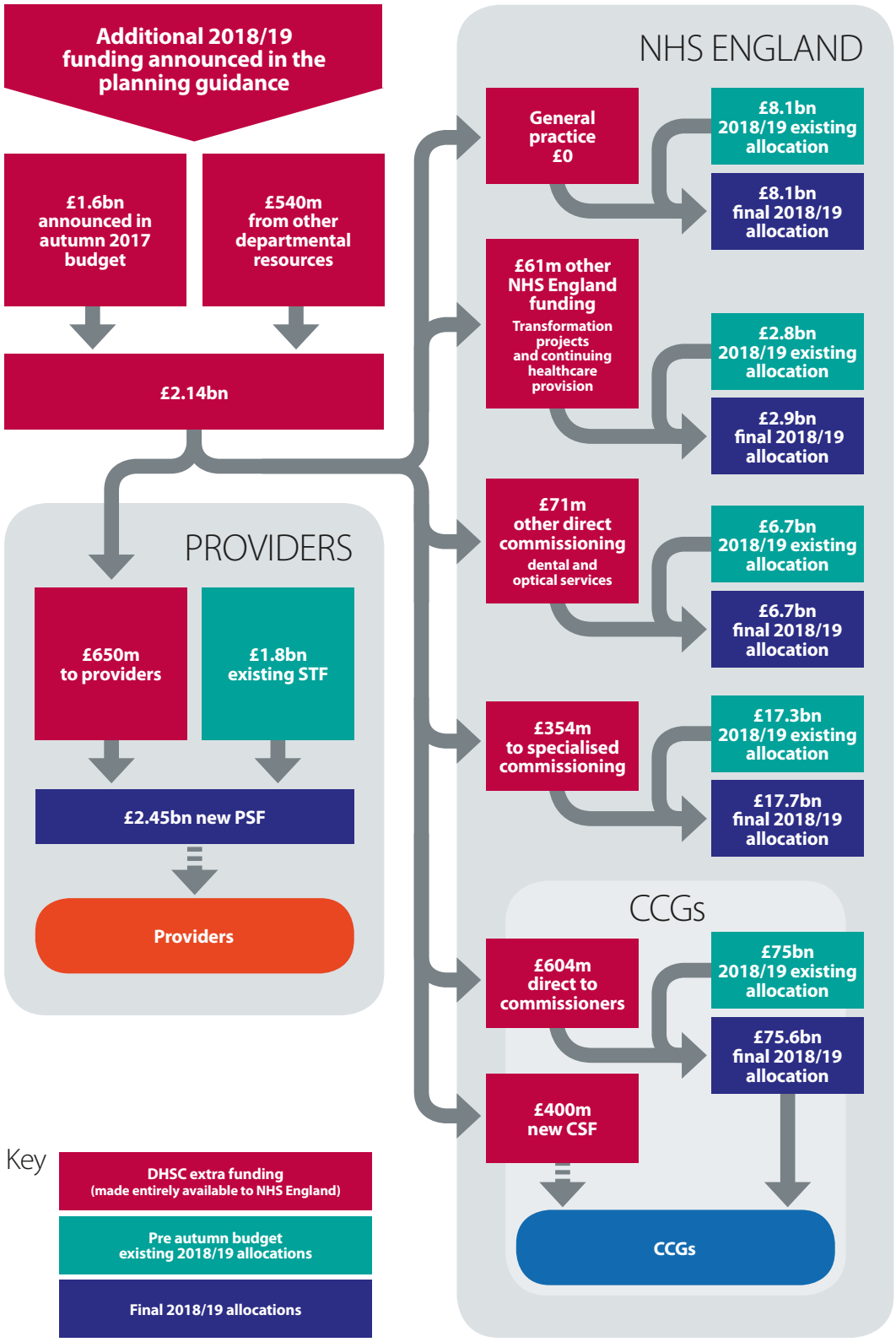
Context

The middle year of the spending review period – 2018/19 – set a very tough financial settlement for the NHS. Funding was expected to increase in real terms by only 0.5%, the lowest increase over the spending review period and well below the average increase of 3.7% per year since the creation of the NHS in 1948. Without extra funding the NHS would have faced a £4bn gap in its finances next year (Nuffield Trust, Health Foundation, King's Fund, 2017).

In November 2017, the government announced an additional £1.6bn for 2018/19. This was welcome but fell well short of what the NHS needed to close the gap. This will increase the DHSC's budget by 1.4% in real terms or, considered another way, by just 0.7% per head of the population (King's Fund, 2017). This is below the 1.2% per person spending rise in 2017/18.

In the planning guidance, *Refreshing NHS plans for 2018/19*, the government topped up the £1.6bn with £540m from other DHSC funds. Increases were made to commissioner allocations, the provider sustainability and transformation fund (renamed as the provider sustainability fund) and a new commissioner sustainability fund (figure 6).

Figure 6
2018/19 funding flows following the 2017 budget



In exchange, the NHS trust sector was asked to deliver a breakeven position, something it has been unable to do since 2012/13. NHS trusts were also issued with a revised control total – a financial target determined by NHS Improvement that all trusts are required to achieve in order to unlock additional funding. These were adjusted as part of the planning guidance but crucially the efficiency expectations built in to these targets remained largely unchanged.

The prognosis for 2018/19

Even before 2018/19 has started, provider finances are on shaky ground. Progress in reducing the deficit has stalled this year as demand and cost pressures increased. To put it simply, the gap between the amount trusts are spending and the income/funding they receive has continued to grow. This makes next year's finances even more challenging as we will be starting with a bigger hole in provider budgets, even with the additional funding announced in the budget.

By the end of December 2017, the sector was forecast to end the year £930m in deficit (up from £496m deficit plan at the start of the year). This looks set to worsen: of those trusts which were already behind their financial plan at quarter three, 60% told us that their financial position has deteriorated further, primarily as a result of the pressures the NHS has faced this winter. As NHS England's chief executive Simon Stevens said, February was "the most pressured month ever for the NHS" (West, 2018).

There are more signs now that the NHS is being stretched beyond its limits than it was at this point last year. The sector started April 2017 with an underlying deficit of £3.7bn (Gainsbury, 2018), yet based on the current demand projections and cost pressures that is likely to increase further.

Achieving financial balance next year would require the vast majority of trusts to sign up to and then deliver their control totals, the financial target each trust is set by NHS Improvement and agreed, or not, by each trust board. However, when we surveyed trusts in February (just before draft financial plans were submitted) only slightly more than half of trusts (54%) indicated they would to sign up to their 2018/19 control total (figure 7), and, of those, only just over a third (35%) were confident they could meet this (figure 8). Of those planning to reject their control total, the main reasons cited were that the targets were too ambitious given current financial position, and the quality of care could be compromised by unrealistic cost improvements. Another reason provided was that staff morale could be negatively affected by a culture of failure.

Figure 7

Is your trust planning to sign up to your revised control total?

(n=97)

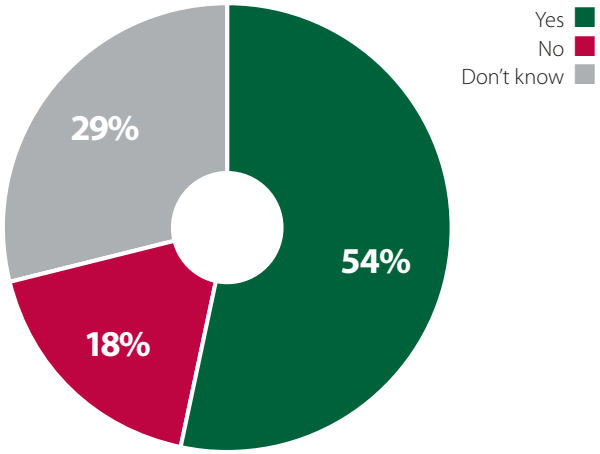
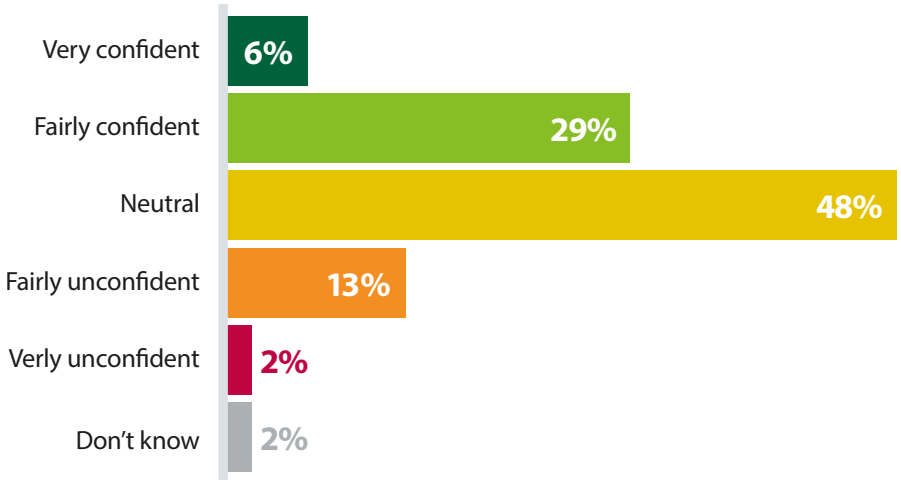


Figure 8

How confident are you that your trust will meet the financial control total for 2018/19?

(n=52)



These concerns are explored in more detail below and can be seen as largely a symptom of a number of key risks in both income and costs for next year.

Table 3
Key cost and income risks in 2017/18

Cost risks	Income risks
Level of savings required	
Capital	
Unfunded pay costs	Level of demand above plan (see section 4)
Cost inflation	Provider sustainability funding
	Mental health investment not realised

Savings required

"***To achieve the position we need to deliver a CIP which is a 6.4% of turnover, for which we have not yet been able to identify any plans***."
Finance Director, mental health trust

"***The control total would require delivering the largest CIP we have ever made...***"
Chief Executive, acute trust

Delivering a breakeven position would require NHS trusts to achieve a level of savings not seen in recent years. The average cost improvement plan would need to be 5.7% of relevant turnover,[1] which equates to savings in excess of £4bn next year. This is 20% more than the £3.3bn trusts are on track to deliver this year. For those trusts not planning to sign up to a control total, their average cost improvement plan increased to 8.2% (figure 9).

The control totals for 2018/19 have not been modified for most trusts since they were originally set using 2015/16 performance, so it is perhaps unsurprising that many are reporting a higher savings requirement in 2018/19 given the deteriorating financial context most have faced this year.

The latest available figures show that the NHS is already delivering productivity gains of 1.8% (NHS Providers, 2018), nine times that of the wider economy (Nuffield Trust, Health Foundation, King's Fund, 2017). All the evidence says that the provider sector cannot deliver in excess of 2% efficiency a year (NHS Providers, 2017). The system has to be realistic about the level of savings it is possible to achieve.

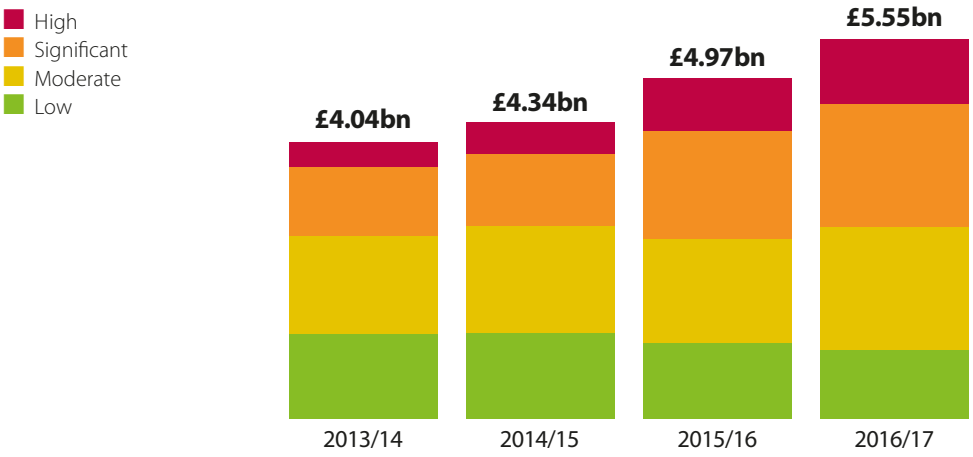
1 For the purposes of this analysis we have used relevant turnover rather than total turnover, which would also include pass through costs, research and development and other income. For the comparison to 2016/17, we have used 2016/17 turnover figures from NHS trust and foundation trust consolidated accounts.

Figure 9
Cost improvement requirement (CIP) for trusts, as a percentage of turnover in 2018/19

Capital

Between 2014/15 and 2017/18, the DHSC switched £3.5bn from its capital budget to the revenue budget, to support day to day spending. The backlog maintenance bill for NHS trusts was already £5.5bn in 2016/17 (figure 10), and this is likely to increase further over 2018/19, as trusts are still under substantial pressure to limit expenditure in this area.

Figure 10
Cost to eradicate backlog maintenance



While this approach to capital may make sense in the short term, it cannot continue. The NHS infrastructure cannot be continually run down without consequences for the quality and safety of patient care.

Continuing this approach will also undermine longer-term sustainability. As the National Audit Office highlighted in its 2018 report, capital to revenue switches have been one of the measures "which have restricted the money available for longer-term transformation" (National Audit Office, 2018).

While the government might have agreed to meet the funding requirements outlined in the Naylor review of property and estates, we are far from a situation where trusts can readily access capital to both meet backlog maintenance requirements, and to modernise and transform healthcare services.

As we enter 2018/19, NHS trusts have little certainty about how much capital funding will be available to them and which STPs it will be allocated to. This means that for many trusts, access to capital funding depends more on the performance of their STP and less on the actual requirements of their infrastructure.

Unfunded pay costs

We strongly welcomed the announcement that agenda for change staff will receive on average a 6.5% pay award over the next three years. We have been told that the Treasury will make £4.2bn of funding available to implement this. However, there are still some questions remaining about whether the award will be fully funded centrally or locally for agenda for change, and whether additional funding will be made available for any uplift above 1% for doctors.

It is crucial that a fully funded pay award is followed through in full. Given the budgetary pressures facing the NHS, an additional cost could not be absorbed by the provider sector.

- **Funded pay award for doctors**: one of the key risks remains about whether a pay award for doctors will be funded by government or have to be absorbed as a cost pressure by the sector. At the moment, the government has only suggested that it would fund a 1% pay award, so anything above this would need to be absorbed by trusts. Taking consultants as an illustrative example, a 2% pay award could cost the sector over £54m, and a 3% pay award would cost over £109m (assuming 1% is funded).
- **Local authority vs NHS commissioned services**: although the government has quite clearly committed to fully fund the pay award, one of the risks might be the extent to which local authority commissioned health services will be funded. Many services provided by community trusts are in fact commissioned by local authorities rather than NHS commissioners, despite staff being on agenda for change contracts. Health visitors provide a helpful illustration of the likely impact as the majority are providing services commissioned by local authorities. Assuming all 8,703 visitors are on a mid point band 6 of agenda for change, using the NHS pay calculator this could add an additional £63m cost pressure to NHS trusts. Given the level of savings providers have had to deliver on these services in recent years, this additional cost pressure could mean a number of services becoming unviable, particularly community services.

The financial sums involved also mean that, through circumstances beyond their control, these providers may be unable to meet their control totals and will also lose access to sustainability funding. This needs to be addressed.

Cost inflation

The national tariff is intended to ensure that prices and contracts reflect current levels of inflation. The tariff for 2018/19 (part of a two-year tariff), increased prices by 0.1% in cash terms. While this is supposed to be net of inflation all the evidence suggests that costs are currently increasing at a much higher rate in the NHS (Gainsbury, 2017).

For example, in 2017/18, official NHS inflation forecasts imply that providers would have to absorb 2.3% of additional cost pressures (table 4). However, according to the Nuffield Trust, there are several signs that inflation has been increasing at a faster rate, which means that providers will have to absorb a higher level of cost inflation than the 2% indicated by the official forecasts (Nuffield Trust, 2017).

Table 4
NHS inflation forecasts[2]

Element	2017/18	2018/19	2019/20	2020/21
Pay and pensions (including drift and mix effects)	2.0%	1.6%	1.6%	2.9%
Drugs	4.6%	3.6%	4.1%	4.1%
Capital costs	3.2%	3.2%	3.1%	3.1%
Other operating costs	1.8%	2.1%	1.9%	2.0%
Overall	2.3%	2.0%	2.0%	2.9%

Even if inflation remains within next year's forecast, their analysis still shows trusts will need to deliver a higher rate of savings just to stand still. The level of recurrent savings that can be made next year will only go some way to cover the forecast increased activity and unfunded inflation. They will do very little to address the underlying deficit (Gainsbury, 2018).

2 For the purposes of this analysis we have used relevant turnover rather than total turnover, which would also include pass through costs, research and development and other income. For the comparison to 2016/17, we have used 2016/17 turnover figures from NHS trust and foundation trust consolidated accounts.
Pay drift refers to the tendency for staff to move to a higher increment or to be upgraded and also incudes the impact of over time.
Staff group mix refers to the movement in the average unit cost of labour due to changes in the overall staff mix (eg the relative proportions of senior and junior staff, or the relative proportions of specialist and non-specialist staff).

Provider sustainability funding

Only those trusts signing up to control totals are eligible to receive provider sustainability funding (PSF). The size of the provider sustainability fund has increased from £1.8bn in 2017/18 to £2.45bn in 2018/19.

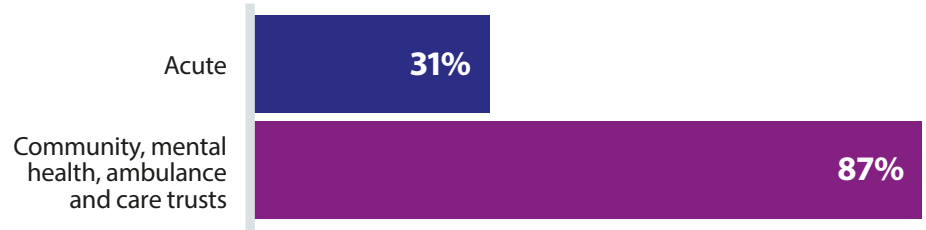
Looking at current performance and our survey findings, there are a number of risks materialising in relation to this source of funding next year:

- Given the higher proportion of trusts not planning to sign up to a control total (18% compared to only 10% this year), more providers are likely lose out on sustainability funding next year.
- NHS trusts are not confident that they will be able to meet the necessary financial and performance targets to access PSF. As reported earlier, only just over a third of trusts were confident that they meet their control total (which gives them access to the majority of the PSF), and only 5% were confident that their local area would meet the A&E performance target (which gives them access to 30% of the PSF pot).
- For 2017/18, 43% of the sustainability funding will remain unallocated at the end of the year, which will then be distributed to those providers which have met their financial control total. Next year, if the same scenario plays out, over £1bn could be left unallocated. Assuming the current bonus and incentive rules stay the same, this £1bn may well be re-distributed to an ever decreasing number of trusts.
- This leads to substantial variation across the provider sector. By December 2017, around half of providers had not been able to unlock their forecast share of sustainability funding. When looked at by type of trust, the situation is worse still in the acute sector, where only a third (31%) have unlocked their full share of sustainability funding, compared to 87% of community and mental health trusts (figure 11) (NHS Providers, 2018).

Figure 11

Proportion of trusts in receipt of maximum STF allocation as at Q3 2017/18 by trust type

(n = 208)



4

Sustainability funding is used principally to support balance sheets, rather than day to day spending or investment. Based on trends in 2017/18, the funding is not always reaching the frontline providers in most need. As one finance director told us last year, the sustainability fund "incentivises good performance but penalises those organisations with the greatest pressures and arguably in need of the greatest support... it has the potential to broaden the gap between lowest and highest performing trusts" (NHS Providers, 2017). The funding is highly concentrated in increasingly fewer providers.

Although one of the key benefits of the PSF is that it remains within the provider sector and can be used to support the aggregate financial position, the scale of the task built in to control totals means that an increased proportion of providers might not be able to rely on this source of income for next year.

Mental health investment

A key priority outlined in the *Five year forward view for mental health*, and confirmed in the planning guidance for 2018/19, is to increase investment in mental health services. CCGs are currently required to meet an 'investment standard', whereby they are required to increase their spending on mental health services at least in line with the growth in their overall allocation.

However, there are warning signs that this is not materialising in to the investment we need. Research from the Royal College of Psychiatrists shows that NHS trust income in 2016/17 was lower in real terms than in 2011/12 and 62% of mental health trusts reported lower income (Royal College of Psychiatrists, 2018).This follows earlier work we did, looking at whether additional commissioner investment was reaching frontline mental health services (NHS Providers, 2016).

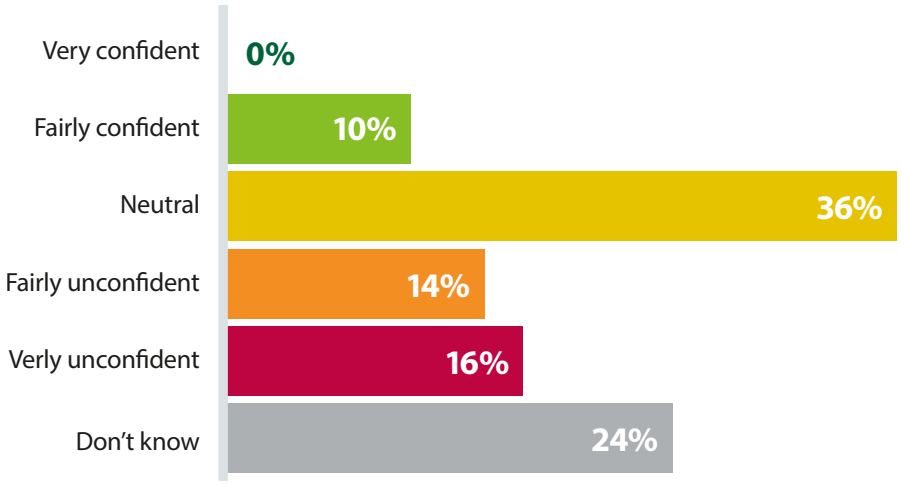
Looking ahead to 2018/19, NHS England has strengthened the investment requirement on CCGs, by introducing an independent validation by CCGs' auditors. Although CCGs funding allocations will grow by 2.2% per capita, this doesn't include the £400m ring-fenced to support commissioner bottom lines as part of the commissioner sustainability fund.

According to our survey, around a third of all trusts (30%) were not confident that their local CCGs would meet the standard in 2018/19 (figure 12). This figure increases to 50% of mental health trusts, underlining their concerns that a key risk for next year is sufficient investment not reaching frontline mental health services.

Figure 12

How confident are you that your local CCGs will meet the mental health investment standard in 2018/19?

(n = 94)



Furthermore, only 3% of trusts (5% of mental health trusts) were confident that the additional requirement for independent validation by the CCGs' auditors would support commissioners to meet their investment commitments. Trust leaders were concerned there is a lack of definition in the guidance when it comes to the investment standard.

"***Whilst the principle is a very positive one, the audit... [will] likely be too late to encourage commitment at the contracting stage for 2018/19 and possibly even 2019/20***".

Trusts will do all they can to meet their financial targets next year, but as things stand the scale of the ask is too high and there is a real risk of compelling trusts to sign up to the levels of efficiency saving which trusts believe are impossible and the Kirkup review confirms are some way beyond what is "generally regarded as the upper end of achievability". The deficit this year is well above plan, because the plan providers were set this year was unrealistic based on levels of demand. We explore what we need to do in response to this in section 5.

5 CONCLUSION

As we set out in *Mission impossible?* last year and subsequent events have proved, the 2017/18 trust ask was undeliverable. As set out in this report the 2018/19 ask looks, taking a very optimistic view, at the edge of being deliverable. Being realistic, it looks some way beyond that edge and unachievable.

We set out in the context section why it is so important that the annual provider task is deliverable. Yet the DHSC and its arm's length bodies (ALBs) continue to set an unachievable task. What could be done to ensure this doesn't happen again?

NHS Providers believes four things are needed:

1 **A change to the planning process**

The current national planning framework is set by DHSC and NHS Improvement/NHS England with Treasury approval and involvement. There is a key missing partner here – the frontline organisations that deliver the planning framework. The DHSC and the ALBs must create a process in which the emerging provider (and commissioner) ask is properly and rigorously tested with the frontline in an appropriate way. This could be through a small representative group whose views are properly listened to and taken account of.

This requires a significant behavioural and process change and will add pressure to an already difficult timetable. But the current approach of the four governmental/ ALB parties negotiating the framework privately and announcing the final result to the frontline is no longer credible and needs to change. It is particularly important that there is significant frontline involvement in the development of the 2019/20 planning framework which is likely to involve a major and substantial reset of the context in which providers and commissioners work.

2 **A new national planning framework**

Future national planning frameworks must be based on the following, which have been lacking in recent approaches:

- **a** realistic demand projections that take full and proper account of current demographic trends and the state of other public services, particularly social care
- **b** a proper safety and contingency margin against events such as flu outbreaks which can have a significant impact on NHS trusts
- **c** realistic assumptions about the speed, size and consistency of delivery of change and transformation benefits that recent national planning frameworks have consistently over estimated
- **d** recognition that, after eight years of the longest funding squeeze in NHS history and in the midst of widespread workforce shortages, the NHS is currently inherently unstable and management capacity is in very short supply, given the time and effort needed to ensure day to day operational delivery.

3 Match the funding to the task in hand

Ensure that the framework matches the task presented to trusts with the funding available. NHS performance statistics over the last three years show that we have clearly now reached the point where the NHS is no longer able to deliver its constitutional standards without significant extra funding and capacity, and a means of addressing current workforce shortages. In the absence of these, the NHS trust task has to be redrawn accordingly.

4 A fully funded, effective, short- and long-term plan to address the current workforce shortages

Workforce capacity is significantly affecting current trust delivery capability. While we welcome the current draft workforce strategy, it needs a matching clear commitment to fully fund its final conclusions. And we need a more detailed, effective, plan for the short term to fill current gaps while the long-term supply envisaged in the strategy comes on stream.

ANNEX
a note on data

Methodology

Survey of finance directors and chief executives

Following the publication of the 2018/19 planning guidance we surveyed finance directors and chief executives at NHS trusts in England. The online survey was open for a week at the end of February 2018.

97 NHS trusts and foundation trusts responded to the survey, representing 42% of the sector. The majority (80%) of responses we received were from finance directors at trusts, and 20% of responses were chief executives.

Additional analysis

Where we have made any assumptions or forecasts in the analysis contained in this report we have added some additional explanatory notes.

Forecasting A&E attendances, emergency admissions and A&E performance

Step 1: To forecast growth in demand for next year, we have first projected what the end of year position will be at the end of March 2018. The latest data available for A&E is February 2018. Therefore when forecasting the end of year position for 2017/18 we have taken the average over the previous 11 months and scaled it up to cover 12 months to get an end of year position.

Step 2: All forecasts for 2018/19 are based on the assumption that the growth will be the same for 2018/19 as we forecast it to be at the end of year position for 2017/18.

Example: The NHS has had 21,831,053 A&E admissions from April 2017 to February 2018. We forecast this to be 23,815,694 at the end of March 2018. This is a 1.9% growth from 2016/17. We predict that if growth holds at 1.9% there will be 24,268,192 A&E admissions next years.

Referral to treatment

NHS England publishes data on the referral to treatment waiting time list. The number of trusts submitting data to the data set varies from month to month. However, Rob Findlay publishes more accurate data that includes non-reporting trusts and we have used March 2017 and January 2018 data for our calculations.

Health visitor pay

The agenda for change pay offer has now been announced. A detailed breakdown of what the pay announcement will mean for each agenda for change band can be found here: www.nhspay.org/pay-calculator

For our illustrative example used in the report we have based our calculation on the assumption that all health visitors in the workforce are at the mid point (25) of band 6 on Agenda for Change, and we have assumed that all health visitors would be providing services commissioned by local authorities.

Doctors pay

Any pay award for doctors is still unknown. For our illustrative example used in the report we have based our calculation on the average 2016/17 consultant salary (£118,153) published in the Department for Health and Social Care's evidence to the doctors pay review body (Department for Health and Social Care, 2018) and the latest available workforce numbers from NHS Digital (NHS Digital, 2018).

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Interactive version

This report is also available in a digital format via:
www.nhsproviders.org/tough-task

NHS Providers is the membership organisation and trade association for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS foundation trusts and trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate.

NHS Providers has 99% of all trusts in membership, collectively accounting for £74bn of annual expenditure and employing more than one million staff.

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